

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 34112

BIRTH NO. _____		REG. DIST. NO. 2		PRIMARY REG. DIST. NO. 5017		Registrar's No. 79	
1. PLACE OF DEATH a. COUNTY Andrew Co				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Andrew			
b. CITY OR TOWN near SAVANNAH		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN near SAVANNAH		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Cordie				c. (Last) COTTMAN		4. DATE OF DEATH (Month) (Day) (Year) 10-13-1952	
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH 12-25-1879	
9. AGE (In years last birthday) 72		10. MONTHS 9		11. BIRTHPLACE (State or foreign country) Andrew Co Mo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John Etchison				13b. MOTHER'S MAIDEN NAME Caroline Graves		14. NAME OF HUSBAND OR WIFE Sam Cottman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mark Schaffer Savannah Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malra Stenosis and Aortic insufficiency ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 410X				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from Aug 1952 to Oct 12, 1952 that I last saw the deceased alive on Oct 13, 1952 and that death occurred at 2:45 A.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) A. Kelley M.D.				23b. ADDRESS Savannah Mo		23c. DATE SIGNED Oct 13-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 10-15-1952		24c. NAME OF CEMETERY OR CREMATORY SAVANNAH		24d. LOCATION (City, town, or county) (State) SAVANNAH MO	
DATE REC'D BY LOCAL REG. 10-13-52		REGISTRAR'S SIGNATURE (Signature)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Breit Funeral Home Savannah Mo			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Per — Permitted Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*E. L. Breit*

Licensed Embalmer No. *2650*

P. O. Address *Savannah, Ga.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.